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CONTENTS

EDITORIAL

Five Years' Progress

Both the Minister of Health and the Secretary of State for Scotland marked the fifth anniversary of the "appointed day" for the coming into operation of the National Health Service with letters of appreciation for the achievements of all concerned with the first five years. These letters were addressed to the chairmen of regional boards, boards of governors, management committees and local executive councils and to the civic heads of local health authorities and rightly stressed the very large element of voluntary public service in that winning of the health services.

With the copies of these letters which reached us were attached some figures regarding the work done by the Service contrasted with figures (where available) for the pre-1948 period. These indicate real achievements in the increase of hospital beds and staffs, in the supply of appliances, dentures, spectacles and hearing aids, in prescriptions and in all forms of treatment; nor do we think that all this curative activity should be decried as an extravagant piling up of national expenditure. But the nation is faced with the inseparable fact that the sum total of disease does not diminish and that the price of cure or alleviation grows from year to year, partly owing to the increase in the costs of all materials and services, partly because of the very progress of medical science.

So the sixth year of the National Health Service begins with the Committee of Inquiry into its cost, to which the Society of Medical Officers of Health will itself be presenting evidence in due course. Now, if ever, the time is ripe for putting forward to an independent tribunal our cherished conviction that prevention is better and cheaper than cure—and if possible of producing evidence in support of that view. We know how difficult it is to prove the cash value of disasters which have not happened, of children who have developed into full health, of lives saved and of handicaps overcome—But it is of these achievements and of their possible extensions that we must convince not only the Guillebaud Committee but also the rest of the profession and the tax- and rate-payers as a whole.

The question of the reform of the National Health Service is inevitably bound up, in the long run, with that of local government. The numerous health functions of local authorities (including those of the School Health Service) and their demarcation from the services directly provided under the N.H.S. Acts, are never clearly understood, except by those directly concerned with their administration—and co-ordination of health services provided under the various enactments and administering authorities has become a task confronted with which Hercules himself might have felt that it was time to take up his superannuation pension. The sub-committee of the Association of Municipal Associations, whose report the reform proposals by the other associations has recently been issued, are in no doubt that the only method of local government administration which does not lead to inefficiency, confusion and frustration is that of the single tier "all purpose" authority. Whilst the Society's past policy is largely in agreement with that view, the linking of local authority health services with those of the other authorities in the National Health Service is equally desirable and involves yet more hard thinking.

Remuneration of Assistant Medical Officers.—M.D.C. Circular No. 17, issued on July 9th, 1953, by the joint secretaries of Medical Whitley Council Committee records that both sides of the committee have accepted the Industrial Courts Award No. 2452 and recommend its adoption by all local authorities in England and Wales and Scotland.

The Council of the British Medical Association has given notice that advertisements not conforming to the award or from authorities which have not implemented the award for all posts will not be accepted for publication in the *British Medical Journal* on and after January 1st, 1954.

THE DIAGNOSIS AND TREATMENT OF SPASTIC PARALYSIS IN CHILDREN*

By EIRENE COLLIS, C.P.T., M.C.S.P., M.A.O.T., O.N.C.

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I am very grateful for the opportunity of offering to the most important body of medical men and women at present dealing with the infantile cerebral palsies a few observations made over the past eleven years of close study of normal and neurally deficient infants and children. We have, in this time, examined over 2,000 cases showing varied defects of central nervous origin and compared them with normal children of the same ages. This unique opportunity for study was provided initially by the London County Council, and we cannot help feeling that the interest aroused all over the world in the Cerebral Palsy Unit at Queen Mary's Hospital for Children, of which Dr. Agassiz is now the Physician Superintendent, justified this initiative.

Though it was Phelps of America whose work for cerebral palsy inspired this Unit, originally under the direction of Mr. E. S. Evans, former Medical Superintendent of Queen Mary's Hospital, we deviated from the orthopaedic approach at the very outset of our work, and began to study and treat the cases presented from the point of view of neuropaediatrics. Some three or four years later, I was fortunate enough to be sought out by Dr. William Dunham, who had been working in the related field of the adult cerebral palsies, and so obtained his invaluable collaboration in the study already begun at Carshalton. The Medical Research Council has now, as you probably know, provided us with an opportunity of extending our joint work to include the study of these neurophysiological defects in young infants. Here again, the London County Council has offered its inestimable support, and the Ministry of Health and our respective hospitals have enabled us to set aside time for the work.

Dr. Agassiz has devoted time and interest to widening the scope of the original unit at Queen Mary's Hospital. The first advice clinic in the country to which parents of motor deficient children could come for the help they were even then demanding in that important aspect of treatment —the home care of their children—was set up at the Lambeth Hospital. This clinic has proved of value to parents from all over England and from other countries, but we wonder if the Medical Officers of Health are always clear about the nature of the service it offers. In fact, this clinic offers a new approach to the cerebral palsy problems—an approach which is the outcome of long study and experience. Both mental and motor processes are exhibited in physical activity. Analysis of this in respect of the age of the growing child shows that change occurs as maturation proceeds. Where central nervous abnormality is present, physical activity exhibits deficiency as maturation of intact structures occurs. From analysis of this deficient activity may be deduced the function, mental and motor, remaining to the affected child. The advice given to parents is based on detailed appraisal of this remaining function—upon which the possibilities of compensation depend.

Recent publicity about the so-called spastic child has but given wider prevalence to the erroneous concepts that gross abnormality and deformity are necessary sequelae of infantile cerebral defect, and that a variety of therapeutic techniques is available for choice when considering the amelioration of these developments. Yet, when motor deficient infants are examined in early life, signs of defect are not apparent in the majority of cases. Gross abnormality in infancy is found only where the prognosis is grievous under any circumstances. There is little doubt, however, that neural defect *is* present from the time of birth in the great majority of cases of infantile cerebral palsy, and hence the small presciences of abnormality for which many such infants are first brought to the doctor are of significance. These may include defects of breathing, sucking and swallowing, which though they often persist into childhood, pass unnoticed. Many normal babies, however, transiently exhibit similar signs, and hence careful examination, repeated at suitable intervals, is the only means of early diagnosis. Yet, methods of neurological examination of the adult subject are inapplicable to infants. A new system of neurophysiological examination of infants is, therefore, eminently desirable, and for a few years now Dr. Dunham and I have been concerned with this problem. Apart from the careful analysis of early signs of gross neural defect by Craig[1], and the large volume recently published by André-Thomas[2] on normal infant development, little new material has since come to light, and we are venturing to publish in the near future some of our own findings.

We believe that most cases of infantile neural abnormality, not excluding mental defect, can be detected in about the fourth month of life, and that in cases of uncomplicated motor dysfunction relatively normal activity can be attained in childhood where early appropriate treatment is provided. This means that, in such cases, deformity, speech defect, and abnormal methods of locomotion can largely be avoided, and affected subjects enabled to go to normal schools and lead normal lives. In cases of mental defect, however, the prognosis is less favourable since ultimate achievement is limited by mental incapacity. The work carried out in the Cerebral Palsy Unit at Queen Mary's Hospital lends considerable support to these views. Dr. Agassiz himself has, during the past three or four years, endeavoured to ensure that children are referred to him at a younger age than formerly. An interesting result of this has been the constant referral to Carshalton of mentally deficient babies, a number of whom have no *motor* dysfunction. This fact seems to indicate that although *retardation* is readily recognised in infancy, early diagnosis of infantile cerebral palsies is not yet common. However this may be, many motor deficient children presumably still pass for normal until deformity develops.

A few years ago, evidence of motor defect of central nervous origin in children was often considered evidence of mental defect. Where such children could not speak intelligibly, nor read, nor write, and moved in an abnormal manner, they were regarded as idiots. Then, for a space, it was supposed that most affected children were of high intelligence, but unable to exhibit this because of motor abnormality. We found that where we were able to institute appropriate continuous treatment at a relatively early age, normally intelligent children became able to exhibit their mental capacity through their achievements; mentally deficient children failed, in greater or lesser degree, in achievements. Thus, in these cases, there was no subsequent difficulty about *mental* assessment. With regard to the physical activity occurring in the presence of motor abnormality, it may sometimes be difficult to give this a name. This brings me to the vexed question of terminology. It is generally agreed that the terms spasticity, athetosis rigidity and ataxia, may be used singly to describe four separate syndromes of motor dysfunction of central nervous origin which develop from infancy onward. We use these terms in this way, and thus related phenomena in any given

*Paper given to the Metropolitan Branch, Society of M.O.H., February 13th, 1953.

case are included in the single diagnostic term. For example, the insecurity of posture occurring in cases showing the clinical sign of spasticity is recognised to inhere in the syndrome, and hence is not confusingly described as coexistent athetosis or ataxia or both. The term athetosis we reserve for cases where, in the presence of normal thought processes and in the absence of the element of unsteadiness of movement, activity shows inco-ordination and stiffness which is clinically differentiable from spasticity and rigidity.

It is confusing when the words spasticity and rigidity are used as syndromes for stiffness, and athetosis and ataxia as synonyms for incoherent activity. Incoherence of movement is a feature common to mental and motor dysfunction, and stiffness is encountered at some stage in most types of infantile cerebral disorder. The reasons for incoherence of movement and stiffness are not identical in different types of case. We base the diagnoses on the entire syndrome and not upon separate abnormal features; thus, only where related signs of clinical spasticity are found is a diagnosis of spasticity given, other signs are noted and their origins assessed.

A form of classification fortunately fast becoming obsolete is that made according to obvious limb involvement, *e.g.* quadriplegia, monoplegia. This is not diagnosis. The term hemiplegia, though also not diagnostic of the type of dysfunction present, usefully distinguishes unilateral spastic disablement. Hemiplegias of infancy, however, differ from adult hemiplegias as distinctly as other infantile conditions differ from those of adults. Rather than discard well-known terms we use the sub-divisions of infantile cerebral palsy already enumerated, and distinguish quadriplegia from hemiplegia by the word generalised, *e.g.* generalised spasticity. Where we find coexistent defect of the special senses or abnormality of sensation we note these. Distinction in physical activity of signs of mental defect from signs of motor defect is also made and added to the diagnosis. This seems better than adding to the terminology already in use.

Recognition of the different syndromes depends, of course, on interpretation of clinical signs. Interpretation may be difficult. Signs vary with the age of the child, the degree and type of motor dysfunction present, the child's mental status, and the effects of previous activity and physical handling. Yet it is important, at all stages of evolution of these syndromes, that the diagnoses be accurately made in order that treatment may be appropriate. In some cases of central nervous defect, mental processes are intact and physical activity is deficient only in respect of motor function. In others, the converse is true, and, in these, palsy is absent. In still others, both mental and motor processes are deficient. Though motor deficient children do not exhibit palsy syndromes at birth, they enter life with the potentiality for their development. We believe that whether or not these syndromes attain their maximal abnormal forms depends almost entirely upon the physical handling which affected babies and young children receive; even mentally deficient infants need not develop gross deformity as the result of their motor defect, though they fail in normal achievements as a result of their mental defect. I venture to suggest that the ultimate aim of treatment should be the utilisation by the child of his residual neural apparatus in such a way as to produce normal physical activity. Normality or abnormality of utilisation is, however, is dependent upon the mental status of the child. While physical treatment can arrange the most economic means of circumventing *motor* dysfunction, it cannot ensure normal attainments by a mentally deficient child.

The fallacy that deficient physical activity is influenced only during the periods of organised therapy is widespread. It is overlooked that *all* handling of whatever kind affects, over a period of time, the activity of motor deficient children. A further fallacy is that any form of intermittent organised handling such as traditional physiotherapy techniques, necessarily *decreases* abnormality. Abnormality may be, and, regrettably, often is, *augmented* by such techniques. Elicitation of abnormal signs is always an object of examination, but under no circumstances should it be an object of treatment, which should be designed to eliminate and not to facilitate abnormal reactions. Thus, in spasticity, abnormal signs are elicited every time external force is employed, and yet the intermittently applied force of stretching and the constant force of splinting is commonly advocated. Another common fallacy is that since during periods of quiescence of activity abnormality is not apparent, this does not exist at these times. Reflection shows, however, that his deficient nervous activity is all the cerebral-palsied child has to make use of. If he is to do this efficiently he requires adult help based upon accurate analysis of remaining function and understanding of the way in which development proceeds as mental processes evolve in the child. Where there is spasticity this decreases as utilisation increases. Utilisation remains a function of the child himself, no other agent than the child can execute his voluntary movement. Where there is a defect of intelligence, it is utilisation which is impaired, and this cannot be enforced by therapeutic or other means. With appropriate treatment, however, achievements become more easily attainable by the child who profits from this in accordance with his mental capacity.

Treatment of cerebral palsy motor dysfunction is simple, but exacting. Constant vigilance is required to see that, as far as possible, attitudes and activity simulate those of normal subject of the same age. No special equipment is needed for this, though ordinary furniture in use must fit the child and not the child the furniture. Parents and others must be carefully instructed in ways of carrying, seating, feeding, and dressing affected children so as to foster normality of appearance and behaviour. A few minutes each day may be usefully spent in helping palsied children to concentrate upon particular aspects of activity, including that of speech. It may be argued that busy mothers have no time for constant meticulous attention to a child's activity. In our experience, they not only have time, but also show the same joy and pride in the hard won attainments of their afflicted children as in the easier ones of their normal children.

Assessments of Spastic Dysfunction

Before treatment is instituted, careful analysis of the child's deficient activity is essential. We have found enlightenment not only at the examination itself, but also from the detailed histories obtained from the parents. From accounts given in 2,000 cases we have noticed a relation between these and the findings at examination. For example, with a history of "rhesus incompatibility," a finding of mental defect and variable rigidity has been the rule: in contrast, with a history of asphyxia livida, and in the absence of rhesus incompatibility, "fits," and physical assymmetry, athetosis may be found where there was failure to establish normal sucking and swallowing; again, absence of any abnormality in the birth and neonatal history is usual in cases of uncomplicated mental defect.

At physical examination, incoherence of activity due to motor dysfunction is usually distinguishable from incoherence of activity due to mental defect. The distinction is made on the presence of co-existent signs of each type

of defect. Mental defect, in our experience, frequently accompanies clinical spasticity, but this does not alter, though it may retard, the evolution of uncompensated spasticity from latency to classical form. During the early weeks of life, normal infants show resistance to passive straightening of their limbs. Where this infantile resistance persists abnormally, retardation in the utilisation of movement may be suspected; this implies mental defect. In cases of mental defect also, the well-known hypotonicity of infants persists abnormally. Where, on the other hand, motor dysfunction exists, young affected children of normal intelligence are hypotonic. Thus, a hypotonic state is always found in cases of latent spasticity. Leaving aside signs of mental defect, may I draw your attention to a few diagnostic features in cases of generalised spasticity? Where this is latent, resistance may be encountered on firmly grasping the ankles of the supine child, rotating the thighs inward, and sharply abducting the legs. Taken by itself, however, no sign is convincing evidence of abnormality, and where such resistance is encountered in a child, further evidence of spasticity must be sought. With the child in the prone position, with his pelvis held in firm contact with the surface on which he is lying, if one of his legs is passively flexed at the knee and a moving stimulus firmly applied to the sole of that foot, the hip on the same side shows flexion. This reaction differs from the infantile "withdrawal" from the stimulus, which may persist in retarded children with and without spasticity.

With increasing age, uncompensated latent spasticity gradually develops its recognised clinical form. At this stage of dysfunction, resistance to passive stretching of a limb is evoked only when traction is *sharply* applied to counter the postural tendency. Force applied meets with no resistance where it *assists* the return of the limb to its habitual posture. The two signs described develop into classical spasticity as follows:—

With the child in the supine position, when the ankles are grasped, the thighs rotated inward and sharply abducted, resistance is still encountered, and, in addition, the hips and knees show flexion and the lumbar curve increases. This reaction is in contrast to that obtained from the normal child and the motor deficient child with no spasticity.

With the child in the prone position with the legs extended, when the pelvis is held firmly down and one leg passively flexed at the knee, the hip on the same side flexes. There is no necessity at this stage to stimulate the sole of the foot to obtain this reaction. The reaction is not seen in the normal child nor in the abnormal child with no spasticity.

With the child supported in the side-lying position with the legs extended, when the uppermost leg is passively drawn backward and abducted, the under leg rises off the surface on which it was placed. This again is not seen in the normal child, nor in the palsied child with no spasticity.

With the child suspended by the ankles in the upside down position, the feet show plantar-flexion. This is not seen in the normal child though it occurs in types of motor defect other than spasticity. In spasticity, on release of one ankle, the freed leg may remain extended: on pushing the extended free leg into flexion and then releasing pressure from the sole of the foot, the leg may spontaneously return with characteristic precision to its former extended position. The normal reaction is quite different and varies with age, and an abnormal, but differing, reaction occurs in the motor deficient child with no spasticity.

Where these signs are present, a further sign may be found which is of clinical importance in that where it is manifest after spasticity is established, dislocation of the hip is not infrequently present, or supervenes. With the child supported in the side-lying position with the legs extended, when the uppermost leg is passively drawn backward, abducted, and then released, it flexes and *falls* on to the surface on which the child is lying. Where hypotonus is conspicuous and spasticity latent, this reaction is always found. It does not occur in motor deficient children with no spasticity, nor in normal childern.

In addition to the signs of spastic dysfunction already described, the following anomalies may be encountered:— The thumb lies across the palm of the hand, and shows little or no voluntary activity. The abnormality here seems comparable with that found at the hip joint. The fact that flaccid functional weakness may oppose spastic functional weakness in the movements of a limb was commented upon by Phelps in 1941. Characteristic deformity, where this is allowed to develop, may involve the whole body. The classic attitude of the "spastic diplegic" includes: flexion of the neck, hunching of the shoulders, flexion at the shoulder joint; adduction of the arms, flexion at the elbow, pronation of the forearms; adduction and flexion at the wrists, flexion of the fingers over the flexed thumb; narrowness of the chest with "sinking-in" of the lower end of the sternum, kyphosis; a rounded lumbar region (especially noticeable during attempted sitting on a flat surface); an adducted attitude of the legs, frequently with crossing at the ankles and semi-flexion at the hip and knee: the attitude of hip and knee flexion is maintained in the prone position: plantarflexion at the ankles, and "pronation" of the feet, with extension at the great toe.

Traditional neurological signs are found by the time spasticity has developed. The tendon jerks show characteristic brusqueness with checked range of movement; this is usually particularly well evidenced at the knee joints. Clonus which is abnormally sustained may frequently be easily elicited at the ankle joints, especially with the child in the prone position with the knee kept passively flexed during application of the stimulus. The great toe extends in a characteristically deliberate manner upon the firm application of a moving stimulus to the sole of the foot. Blueness and coldness of the limbs, especially of the legs and feet, are often present. Chilblains commonly occur.

In the absence of hearing defect, speech is unaffected in intelligent children with spastic dysfunction, though its appearance may be delayed. The imperfect speech of mentally abnormal children is, however, often mistaken for motor dysfunction, especially where mastication is also imperfect, and dribbling is present. In some cases of mental defect, precocity of mannerisms and "chattering" speech are exhibited. Signs of retardation commonly encountered in mentally abnormal spastic children may include: strabismus; relatively unmodified reflex palmar and plantar grasping; fanning of the fingers and toes; rotation of the trunk and legs to the side to which the head is passively turned with the child lying supine: "stepping" reactions; the "withdrawal" reaction previously mentioned; a relatively unmodified Moro reflex.

In conclusion, the subject to which I was asked to contribute was the various developments in the diagnosis and treatment of spastic paralysis in children. This is a tremendous subject and, as I said in the beginning, lies in the rapidly unfolding field of neuropaediatrics.[3] I ask your indulgence for taking up so much of your valuable time, though I have yet left three-quarters of the subject of the infantile cerebral palsies untouched. This includes early signs of central nervous defect, the differentiation of physical signs of mental defect from those of motor dysfunction, and analyses of the developing syndromes of athetosis, ataxia, and variable rigidity, as well as that of

spasticity, including the infantile hemiplegias. All these subjects form the material of a series of papers now in preparation by Dr. Dunham and myself. Spasticity with mental defect is—unfortunately—probably the commonest of the infantile cerebral palsy syndromes, and if you have had put before you, in regard to the signs in infantile spasticity, a few points new to you I shall feel well satisfied.

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THE CEREBRAL PALSIED CHILD*

By C. D. S. AGASSIZ, M.C., M.D., F.R.C.P., D.P.H.,

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The problem of the handling of the child, or adult, with cerebral palsy is a difficult one and offers many facets for observation, suggestions and criticism, but I suppose the first facet is that of correct diagnosis, because on correct diagnosis depends, in large measures, the results we may reasonably expect from treatment, and upon it depends our estimate of the result we may just fiably expect.

Diagnosis

I emphasise the importance of correct diagnosis because I have a feeling that many of the deductions which have been made from observation of cases have been drawn from those in which the correctness of the diagnosis is open to doubt, and hence the deductions drawn may be inaccurate. In this condition it is so easy to make a wrong diagnosis and so difficult to make a correct one, and few people see many cases, so are unable to gain sufficient experience in diagnosis. In the past the tendency has been to leave the child until definite evidence of abnormal movement, or lack of movement, is present for all to see and then to concentrate on treating the resultant orthopaedic condition.

And at this stage, greatly daring, I would suggest that the orthopaedic surgeon is not the man to whom such cases should be referred, though when deformities have developed he may be called in, but our object should be to prevent deformities rather than to try to cure them.

The number of cases of cerebral palsy in any district, except large towns, must be small—the total for the whole country is not known but estimates of 10,000 to 30,000 probably cover it—so that the number of cases that any one man in a district can see is very limited.

The first essential, therefore, should be the establishment of special centres for diagnosis where experience can be gained and where the problem can be more accurately assessed. In the past, owing to the fact that cases have been left when they are discovered, they are severely handicapped physically and mentally, and with every year that passes these handicaps become more marked so that such children either are taken into the schools for physically handicapped children, or drift into institutions for cripples or mental defectives.

At this late stage there is probably little else that can be done, and whatever steps we take there will be a proportion for whom some such provision will have to be made, but on economic grounds alone, to mention no other, we should endeavour to restrict this proportion to the smallest possible size.

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It is quite evident from the results we have obtained at Queen Mary's Hospital for Children that if one can get these children before they have developed abnormal movements and deformities, and provided their mental condition is potentially normal, their development of normal functional movement and mental capacity can be so directed that there is every prospect of them taking their place in an ordinary school, or a school for physically handicapped children, and, provided they are handled correctly and the people who deal with them understand how the child should be dealt with, their development along normal lines will continue.

If this statement is correct then it is obvious that it is essential that such children must be picked out in infancy and, therefore, that those working in pre- and post-natal clinics and welfare clinics should be aware of the possibility of such infants turning up and should be on the watch for them. The mothers so often tell me they noticed the child did not appear to be developing normally, but when they point this out they are told the child will grow out of it or is late in developing. If the clinics and hospitals were more aware of the possibility of cerebral palsy and would refer such cases to the special centre I have suggested, we should soon be on the way to solving the problem of the cerebral palsied child so far as it is soluble.

Varieties of Cerebral Palsy

Of the different varieties of cerebral palsy I do not propose to say much—the main types are the spastic and the athetoid, and everyone feels competent to distinguish between these two varieties, but my own experience, and it is based on a fairly wide experience (we see 150 or so new cases at our Cerebral Palsy Clinic every year) leads me to think that much more attention should be directed to trying to make a more accurate diagnosis. Many cases are diagnosed as spastics or athetoids which are neither, but are cases of variable rigidity—a type in which the prognosis and method of handling is vastly different.

Again, many children are sent to us as cases of cerebral palsy which turn out to be plain mental defectives. Other cases are a variety of disorders but not cerebral palsy. I am not referring to these in any spirit of criticism—the more I see of these cases the more difficult I find the diagnosis—but rather to show the necessity of properly established clinics under experienced specialists for diagnosing these cases and not leaving them to the Children's or General Hospital Out-patient Departments.

Treatment

Having once established a correct diagnosis how are these children to be treated? Various centres are being set up in the country advocating various lines of treatment and all getting some results which satisfy them, but the results that are claimed cannot really be properly assessed until we have more accurate information as to the type of case they are dealing with and the severity.

It is probably true that there may be a need for small residential units for some of the most severe cases, but the majority of children could be dealt with at day schools or residential schools for cerebral palsied children. But in all such Units a large part of the instruction should be of the parent as well as the child. The treatment of the child is not a matter of a little physiotherapy every day, or a course of exercises, but of the whole daily and nightly activities of the child, and this has to be supervised not for a few weeks or months but for years. The person who can best do this—one may almost say the *only* person who can do this—is the mother. She must understand what our treatment aims at, and if she is intelligent she can do almost as much as

anyone in the treatment of the child provided she is guided by the expert.

This approach at once raises the question as to what is the proper treatment. The British Council for the Welfare of Spastics is trying to organise a Conference to compare various methods of treatment, and this may be useful as it may show what common factors various schools and clinics use.

It seems to me, however, that when one considers what is the cause of the condition there is really only one approach to the subject of treatment, and where the various clinics have consciously or unconsciously used that approach they have achieved results, and that where they have departed from it, provided the diagnosis has been correct, they have got failure—hence the variety of results obtained by most of the methods.

The one fundamental factor in one's approach to this subject is that the condition is due to brain damage—it is not an orthopaedic condition—and therefore to apply methods of treatment devised to deal with faulty muscular action or consequent deformities is to shut one's eyes to the fundamental cause.

If as a result of brain damage there is a break in the pathway of messages from the brain to the muscles and vice versa, there is only one basic method of treatment to be adopted and that is to reconstitute, if it is possible, the pathway, or substitute some other connecting link between the brain and the muscles.

When we come to consider this we have to bear in mind what is the normal development in a normal baby. The baby at first has no voluntary muscular movement—his movements are involuntary or reflex.

It is only as the nerves become myelinated that he develops voluntary control of muscle, and he achieves that largely from the many varied and repeated impressions from outside and inside that he is receiving all day and every day. Further, that development takes place from above downwards so that the baby first starts moving his head and neck, then his arms, later his body and legs.

In the cerebral palsied child as a result of his brain damage he is very largely cut off from these endless and various impressions so that his development of achievement only goes so far as the very limited impressions he receives allows—that is to say his movements are extremely limited in range and action. Our approach to treatment, therefore, must be founded on the normal development of activity. It is useless to try to make a baby walk before he can stand, and no one in his senses attempts to do so. It is equally useless to try to get a cerebral palsied child to walk before he can use his arms and body properly, but how often do we find such children being made to try to walk with, in most cases, very disappointing results.

In all our treatment we have to try to visualise the problem the child is having to face, and to overcome it by finding a solution which is practicable for the child.

This method of approach applies to every action we want the child to undertake and must be instilled into all those who have to deal with him, and, therefore, all those who are looking after these children must be instructed in the proper method of handling the child so that the picture of movement the child is in consequence building up is a consistent one. For instance, to take a simple example, it is useless for one person to put the child on to a special lavatory seat where he feels secure and can concentrate upon controlling his bowels and for another person to put the child on a chamber where he feels insecure and hence directs his attention to maintaining his balance instead of to controlling his bowels.

In every approach to the child's activities we have to put ourselves in the child's place and to try to visualise the difficulties he has to face, and to find some method of enabling him to produce the particular action or function we want him to try to produce. Once having started on these lines and got the child a little stabilised, we should proceed gradually to enlarge the child's activities.

Education

And now let me turn to another facet of this problem, namely education. Once we have got the child able to sit up and use his hands we should consider the question of education. If we have had the child from infancy or even later the child should be reaching the nursery school age, and at one time we used to have nursery school teachers to teach these young infants but we eventually came to the conclusion that the occupational therapist was, in fact, giving much the same kind of instruction as the nursery teacher and we have given up the nursery teacher. At this age I think this is all that is required, but as the child gets older and more capable physically, one has to turn to instruction by teachers but the teacher must first have worked in a cerebral palsy unit and had instruction in the handling of these children so that she can appreciate the the individual problems that present themselves in each case.

And now we are brought face to face with the problem "should these children be taught in separate classes or should they be taught in classes for physically handicapped children or ordinary classes."

At one time, I was inclined to think that they should be sent to physically handicapped schools and provided the teacher understands what she has to do, that may be a solution, but more recent experience has led me to think that at first at any rate the young child, if severely handicapped, should be taught in a class restricted to cerebral palsied children. Like many other things, one gets better results where the teacher's interest and attention is concentrated on one particular type of disability. They develop almost an instinct for noting changes in the child and are stimulated to develop particular methods of instruction to suit the particular needs of the children they are training. We have to remember that many of these children have disabilities of eyesight, difficulty in focussing, squints, or difficulties of hearing, either complete or partial, which is not always very easy to detect, but which trained teachers are on the look out for and detect more readily than those not so trained. And we have also always got to bear in mind the child's picture of himself which is naturally that he is a normal child, slightly handicapped maybe, but nevertheless normal. The expression of frustration that these children so often have on admission to our unit and the complete change in expression which so quickly follows when the child realises that at last someone recognises his difficulties and is helping him to overcome them, is sufficient evidence of the truth of this as the photographs I submit, show. Once the child has become stabilised, they he may be transferred to a school for physically handicapped provided the teachers understand that they must do for the child and, in less severe cases they may go to the ordinary school.

These children can be taught reading, writing and arithmetic provided the teacher understands what she has to do and adapts her methods accordingly. A child who has difficulty in keeping his limbs still cannot reasonably be expected to hold a pen and to try to write—I have seen it done—but by putting letters on blocks, which he can handle, he can build words, and as he improves these blocks can be

modified to suit his better control, and this may be continued until he can hold a specially large pencil.

All this intellectual development is most important—the more we can train the child's mind the better the physical result will be, but we must remember that the effort of concentration such children have to make is far greater than a normal child of similar age would have to exercise and must be careful not to press the child too hard. In stating this I do not want to suggest that we will completely stop all the movements of the athetoid, or make the spastic supple and free in movement, but we will make the child develop as functional a life as he is capable of though it will take years.

Having got the child to this stage one finds that there are practically no special schools for grammar school education or indeed of special training for the cerebral palsied child who is sufficiently alert mentally, but too handicapped physically, to be able to compete in the outside world. Special schools for senior scholars are badly needed, and special training centres specially for the cerebral palsied adolescent. Once these are established we shall be able to train the most severely affected sufficiently to enable them to earn at least part of their keep. Though the need for such special schools and training centres is great at the present time, I would again stress that if diagnosis was always made in infancy, and treatment commenced then, the need for these special centres, where the children's mentality is normal, would be reduced to a minimum, if indeed they would be required at all.

But having said this, I do not wish to imply that until that happy day comes nothing can be done for children who are not taken in hand until they are past infancy. A great deal can be done for such children if their mentality is normal, but it will take longer and the result cannot be as complete as would have been obtained had it been commenced earlier. When a child has developed some movements of its own accord, they will probably be limited in extent and not of a good pattern and this means that, if possible, a new pattern of movement must be substituted for the old—always a difficult thing to do. But the principle of treatment still remains the same and it is astonishing what results can be obtained in such cases. An outstanding example is of course Dr. Carlson himself, but there are many others.

I need not enlarge further on this fascinating subject, but I trust that the few points I have mentioned have interested you and that they may be of use to you in your work, fully realising as I do that some of the suggestions I have made present great and varied difficulties in execution.

Discussion

Dr. William Dunham, of Charing Cross Hospital, stressed the highly specialised nature of the treatment of the infantile cerebral palsies. Few doctors had either the inclination or the time for study of the complex neuro-physiology of the developing child. And those with such knowledge must be prepared to give detailed instructions, constantly reviewed, to the medical ancillaries undertaking treatment unless those ancillaries were themselves specialists. Of specialist ancillaries, Mrs. Collis was the perfect example, as testified by her appointments as consultant in Crema and Milan, as adviser in Dublin, by her recognition by the Medical Research Council, and by her paper, in which a little of the research work in progress was described for the first time.

But such personnel were scarce. If, in response to the pressure of ill-formed lay opinion, many small treatment units were opened up, neither medical nor ancillary specialist personnel would be available, and the children would suffer.

Instead of the reduplication of small clinics each with its own staff—retreating all too often behind a screen of chromium-plated apparatus and crash helmets from the complex neuro-physiological problems which face them—a few specialist centres in which these problems were squarely faced would bring a greater reward.

Relatively little residential accommodation was, he felt, required; this should be used only for cases of particular difficulty in diagnosis or home management. Most cases responded well under the care of the parents who, with expert guidance, proved to be good technicians, as so well demonstrated at the clinic at the Lambeth Hospital, and as confirmed in his own experience. Visits once, or, preferably, twice a month were satisfactory. For the mental defective, of course, the achievement of a place in normal society was impossible, but for the mentally normal palsied child this should be the aim.

In extending the thanks of the meeting to the speakers, Dr. J. A. Scott referred to the very excellent work that was being carried on in this sphere by all three.

SEMINAR ON MENTAL HEALTH AND INFANT DEVELOPMENT*

By Miriam Florentin, M.B., D.P.H.

Senior Medical Officer, Maternity and Child Welfare, County Borough of West Ham.

The World Federation for Mental Health conducted a residential seminar on " Mental Health and Infant Development " at Chichester from July 19th to August 10th, 1952. Dr. Kenneth Soddy, who is the Assistant Director of the World Federation and Psychiatrist to the Child Guidance Training Centre and the University College Hospital, was the Director of the seminar. Reporting on the seminar to the World Federation, Dr. Soddy said :—

> " Though perhaps we are too close in time finally to assess the value of this seminar, yet I am confident that those who shared this experience will agree that they took part in something of immense significance to the mental health movement as a whole and to the life and future of young infants throughout the world."

I agree with Dr. Soddy about the value of the Seminar and am very grateful that I was given the opportunity and the privilege of attending.

I am going to give you my impressions of the Seminar rather than a systematic account of the three weeks which we spent talking about babies and mental health. It may surprise you to hear that at the end of those three weeks we did not feel weary of our subject nor that we had exhausted its possibilities.

The only exhaustion which was at all in evidence was an emotional one, due, I think, to the effort required in giving of one's best in discussions on ideas which were new to many, and with people who were not only strangers to one another, but had different backgrounds and different professions. This emotional exhaustion was felt even by the most experienced teachers who were experts both in mental health and in the group discussion method. Professor Kent Zimmerman, who is head of the Mental Health Section of the California Public Health Department, compared this feeling to the exhaustion felt by the actor who has given so much of himself in interpreting the character to his audience.

I cannot do anything like justice to the outstanding lectures given by our visiting staff, to the impressive and original work presented by many members of the faculty, to the tremendous amount of detailed work involved in the presentation of the case material and to the skill and hard work of our group leaders. You will, however, shortly be able to read the detailed report which will include the case material.

The World Federation for Mental Health was founded in 1948 and by November, 1950 had a membership of Societies representing nearly one million people, mainly with professional training, in 33 countries. The first aim of the Federation is :—

* Address given to the Maternity and Child Welfare Group Society of M.O.H.

"To promote among all peoples and nations the highest possible standard of mental health, in its broadest biological, medical, educational and social aspects."

Individual persons can be enrolled as Associate Members for the equivalent of 13 Swiss francs (£1 1s. 0d.). Dr. J. R. Rees is the Director, and the offices are at 19, Manchester Square, W.1. I would like to suggest that those of you who are interested in mental health should become Associate Members. This will entitle you to receive the quarterly bulletin of the Federation, which will keep you informed of what is going on in " mental health " throughout the world. I would indeed like to suggest that no one engaged in maternity and child welfare work can afford not to be interested in mental health.

" The idea behind the Chichester seminar," to quote Dr. Soddy again, " was foreseen in the report of the International Preparatory Commission to the Third Internatioanl Congress on Mental Health of 1948, which stated that it would be valuable to gather together key people in interprofessional and international training courses."

In April, 1951, the International Advisory Committee of the Federation, meeting in Dublin, commenced the planning of International Institutes for Research and Training in Mental Health, and as a first step suggested the organisation of a series of short-term courses or seminars.

The seminar was based on a series of clinical studies of actual children, and a faculty of highly qualified people with special experience in this field were invited to teach around the case material, which included a number of films, and to conduct group work.

The decision to start from actual case histories was an inspiration, and made it possible for people of different training, background and language, to proceed by easy stages from the particular and the concrete to the more general and theoretical concepts.

The films illustrated very vividly different patterns of child care and development. The expression on a child's face does not need interpretation into language, and Dr. Mead's film of the bathing of babies in U.S.A., Bali and New Guinea, immediately awakened our interest, stimulated our powers of observation and released our laughter and our tongues.

" The object of the seminar was to gather together people holding influential positions in the public health and child welfare fields in their own countries and to subject them to an international mutual learning experience, in the hope that on return to their work they would have an enlarged horizon, an enriched experience and perhaps more insight into the personal and cultural problems of the people for whom they were working and planning."

" There were other subsidary aims, such as an experiment in a fairly untried method of education, an attempt to establish some consensus of opinion on highly controversial matters, and of course the improvement of the life of the child and his family. Emphasis, however, was on the enriching of experience of people actually in positions of responsibility."

We had no commitment to produce any definite conclusions or recommendations, and I think this was an important factor in the success of the seminar.

The idea of the seminar found immediate support from W.H.O. and particularly from Dr. G. R. Hargreaves, Chief of the Mental Health Section.

W.H.O. undertook to provide sufficient short-term fellowships to ensure that there would be adequate attendance of the kind desired, and also provided money towards the technical services required. The salaries of the members of the Faculty were paid, partly by the Federation and partly by funds from U.S.A., largely as a result of the enterprise of Dr. Margaret Mead, the anthropologist, who was herself at the seminar and responsible for a large share of its organisation. U.N.E.S.C.O. also contributed.

The participants were chosen by their Governments and the Federation was very satisfied with the quality of the representatives. As sometimes happens in governmental activities, there was considerable delay in the nomination of participants, some of whom received very short notice indeed. Their behaviour on arrival seemed to indicate that they felt they had been transported on a magic carpet to some strange land, and were a little apprehensive about the riddles which they might be asked to solve. However, there was much of interest going on, everyone was friendly, creature comforts were well catered for, the grounds were pleasant and spacious and the sun shone (this latter was apparently quite unexpected). Gradually apprehension faded, confidence was established, the Federation club bar got under way and everyone was happy.

The seminar was formally opened by Sir Weldon Dalrymple Champneys, Deputy Chief Medical Officer of the Ministry of Health, at a reception which was followed by a dinner. Sir Weldon delighted and astonished our foreign visitors by giving his address of welcome, not only in English and French, but also in German and Spanish.

Hospitality was extended to the seminarians by many people in the neighbourhood, including the Mayor, the Bishop of Chichester, and the nearby mental hospital Graylingwell. The Regional Hospital Board invited us to a dinner which was preceded by the official opening of the Hospital's new Occupational Therapy Unit, and the Minister of Health attended both these functions. The social organised by the participants was a great success. Each group gave an entertainment. The dramatic account of the Chichester Seminar presented in terms of dance and trance in Bali, the skit on a psychiatric interview of mother and baby presented by an English nursing officer as the psychiatrist, a Swedish educationalist as the mother, and a rotund Egyptian psychiatrist as the baby, as well as the community singing in many different languages, did much to lighten the rather tense emotional atmosphere which the more serious sessions tended to engender.

The participants came mostly from Europe, but a number of invitations were sent to other parts of the world, both to provide a widening of interests and in the hope that future seminars in other continents might be founded on the experience gained at this seminar.

16 European countries between them sent 37 participants and 14 other countries sent one each. There were 22 women and 29 men. 37 of the 51 participants were medically qualified and of these, 19 were psychiatrists. 4 of the psychiatrists were workers in public health departments. There were 8 medical officers of health, 5 M. & C.W. officers and 5 paediatricians in the Public Service. Of the non-medical participants 5 were psychologists, 4 social workers, 1 a psychiatric social worker, 3 public health nurses and one educationalist.

The participants for the United Kingdom were Dr. Anna Gardner, Senior M.O., M. & W., Kent, and Miss Anne Graham, Superintendent Health Visitor, Northumberland. Eire sent Dr. Bridget Thornton, Assistant M.O.H., Dublin.

The Faculty was composed of members of three countries only—U.S.A., France and the United Kingdom, and consisted mainly of teams of varying professions in these three countries who had been engaged for some time in preparing material for the seminar in the form of case histories, films, or original observations. The British team came from Leeds, was led by Professor Douglas McCalman, Nuffield Professor of Psychiatry, and included Professor Meredith, who is Professor of Psychology, Mr. Jocelin and Mrs. Mestel, psychologists and Mr. Fernando Henriques, anthropologist.

A number of the Faculty and some of the participants

were able to bring their wife and family. The children, who ranged in age from one year old Julian Henriques to the adolescent daughter of Professor McCalman, were a welcome and wholesome addition to the international and interdisciplinary community.

The British Faculty members also included Mr. Alan Staniland, Educationalist of the University College of the South West, Exeter, whose ingenuity and technical skill in coping with the headphones and the numerous amateur cinema operators, contributed much to the success of the seminar. His lecture on Visual Aids was most popular.

The official languages of the seminar were English and French, and simultaneous interpretation was provided at all the lectures and plenary sessions and for 4 out of the 5 discussion groups (the 5th group was an all English-speaking group). This procedure was new to me and I found it very intriguing. At the plenary sessions the interpreters sat in a wooden cubicle in the front of which was a rectangular window. This is known as an " aquarium," but I was not able to discover whether it is so called on account of its shape or because of the silent mouthing of the interpreters visible through the windows, silent of course, unless one is wearing headphones. In the group discussions the skill and intelligence of the interpreters can make or mar the learning process which is an intrinsic part of such a seminar. Towards the end of the three weeks our own group interpreter had to leave and was replaced by a charming South American lady, who caused us much amusement as well as confusion. Her knowledge of the language was quite adequate, but she was so astonished by some of the statements made that she could not believe her ears or bring herself to translate them without seeking confirmation from the speaker.

Miss Joyce Akester, Superintendent Nursing Officer for East Sussex, and myself completed the British representation on the Faculty.

When interviewed by Dr. Soddy I noticed with interest his apprehension lest a Public Health Officer would not be able to tolerate such a lengthy seminar whose objects were somewhat nebulous. He was also anxious to be re-assured that I would not feel slighted if I were not allocated what he called " one hour of glory " in the form of a lecture. I assured him that not only would I bear up, but would be delighted. However, I was not to be let off so lightly, and I was asked to speak on " Public Health Possibilities of Improving the Social Care of Young Children."

The Faculty assembled two days before the seminar and spent several sessions deciding how to divide the participants into 5 suitable groups.

The group leaders had already been selected and a provisional division into groups was finally agreed. This aimed at giving as great a variety as possible of nationalities and professions in each group, but also tried to keep together those who had the greater facility in either French or English.

For the very first session the participants were provisionally divided into 5 groups, entirely on the basis of language, and each group was interviewed by 2 members of the Faculty. In this way the Faculty gathered a little more information about the professional training and linguistic abilities of the participants, and a few changes in the original groupings were made. (The psychiatrists seemed to feel at a complete loss about a colleague until they had discovered whether he was dynamically or organically minded. The possibility of his taking up a sensible position halfway between these two schools of thought did not seem to occur to anyone.)

Having got ourselves sorted out we settled down to work. There was a certain uniformity about the daily programme but flexibility was maintained and changes made from time to time. The Faculty held regular meetings and representatives of the participants were elected from each group on to a liaison committee. This committee put up suggestions to the Faculty and arranged some additional social activities.

The day began with a lecture followed by questions and a discussion. After coffee the members re-assembled in their groups to discuss matters arising, either from the case material or from the lectures. The subject matter was not restricted in any way, but after introductions had been made and the difficulties of language surmounted to some extent, most groups made out a programme for themselves.

Representatives of the groups reported briefly to the plenary session every 3 or 4 days so that everybody knew the trend which all the discussions were taking. Following these reports there was usually some general discussion in the full seminar, but these full discussions were the least fruitful of all meetings. due, I think, to the size of the gathering and possibly to the fact that every speaker had to go to the microphone so that his remarks could be translated.

The group discussion continued till lunch time. The periods from lunch to dinner, and from dinner onwards, were free on alternate days on the official programme, but when no social activities had been arranged these were often filled by an additional film showing or meeting of professional groups.

About half way through the seminar the psychologists asked for the groups to become mono-disciplinary instead of multi-disciplinary. The Faculty, however, considered that much of the value and interest of the seminar was due to this mixing of the professions. This view prevailed and we continued to be multi-disciplinary.

The afternoons and evenings which were not free were filled, either by a second lecture, often by a visiting lecturer, or by a discussion, by films, or by a full reporting session.

Over 30 lectures were given, over 30 discussion periods were held, and 15 films were shown and discussed. In our free time the English members who had cars tried to show something of England to our visitors.

The introductory lectures dealt with Child Development patterns in the U.S.A., France and the United Kingdom. Each team dealt with their material in a different way.

For the Americans, Dr. Edith Jackson, paediatrician and psychiatrist, introduced her subject by referring to 2 standard modern books on child care : " Pocket Book of Baby and Child Care " by Benjamin Spock, and " Infant Care, 1951 " published by the Child Bureau of the Federal Security Agency.

She described how, in the U.S.A., they had moved in a wholesale manner from rigid feeding schedules to self regulation, and from " rooming out " to " rooming in."*

It seemed to us that there were still many unsolved problems. The almost universal practice of hospital confinement which is incidentally accompanied by a high incidence of episiotomy, tends to separate the mother from her toddler at a critical moment. The psychiatrists admitted that they were very worried about this but had no solution to offer, nor apparently, had a satisfactory solution been found for the care of the family during the mother's absence The early and continued medical supervision of the mother by an obstetrician and of the child by a paediatrician would

* In the U.S.A. the " rooming in " schemes include not only the keeping of mother and baby together in the maternity unit but also such measures as relaxation exercises and mothercraft training in the ante-natal period.

seem to leave the general practitioner with little interest in mothers and children, and it is difficult to see how he can be a true family doctor.

The French picture was very vividly and humorously presented by Mademoiselle Boutonnier, Professor of Psychology, University of Strasbourg, who introduced in terms of every day family life much of what later speakers presented in more scientific terminology.

In addition to many detailed studies of children and their families, the French team presented the results of an enquiry into " Parent Attitudes and the Behaviour of Young Children " in 3 different cultural settings.

Dividing the families into working class, rural and intellectual, these investigators set out to explore how far the conduct of children is determined by the attitude of their parents, and how far the attitude of parents is determined by their living conditions.

As with the rest of the case material, much time and careful study had been put into this project. Unfortunately, there was not sufficient time, either before or during the seminar, to make full use of this extremely valuable and interesting matter. When the case material is published, I am sure a study of it would be profitable.

Dr. Roudinesco contributed to the French picture by presenting her film on " Children Brought up in Residential Nurseries " which also showed the effect of psychotherapy on a particular child.

The British contribution was introduced by Professor McCalman in two lectures, whose breadth of vision and literary skill made a deep impression. They were illustrated by the film " Life Begins in Leeds," specially made for the occasion.

Other aspects of the British picture were presented by the exhibition, which included play material, clothing and equipment used for infant care, as well as posters, books and pamphlets.

Dr. Fernando Henriques presented the Leeds team's research into the influence of popular journals on child rearing. These magazines were divided into three categories on the basis of the general standards of the articles which they published. Mr. Henriques summarised the advice given on such subjects as breast-feeding, weaning, toilet training, thumb-sucking, etc. Though the manner of presentation varied and might be open to certain criticism, the advice given, was on the whole, both sound and sensible.

The rather vague reference to bad habits on page 50 of " Health of Mother and Child " was regarded as inadequate.

The British case material consisted of 4 case histories, 2 of children who were attending the child guidance clinic, and for comparison, 2 normal children from similar background. The case histories had been complied, not from interviews but from the mothers' replies to a lengthy questionnaire, which is, in itself, of considerable interest.

What are the ideas which emerged from this mass of case material, of original work undertaken simultaneously in different parts of the world, from films produced by psychiatrists and anthropologists and from these international, interdisciplinary discussions ? Nothing that will be startlingly new to my audience today. But you have been interested in mental health for some time, you have read recent publications and have had opportunities for seeing such films as " Grief " and " A Two-Year Old Goes to Hospital," and the French film about " Monique," and many of you have availed yourselves of invitations to attend recent conferences on related subjects. But though there is nothing new, there is much of interest. There is a great deal which, if studied in detail, will enable you to sift the evidence and then to judge for yourselves how much is not yet proven and what is now acceptable as a foundation on which to base our practical work. To do this, however, the work must, as I have said be studied in the detailed report and published case material. Today I can only try to outline for you some of the subjects on which we touched and which seemed to us to have some bearing on mental health and infant development.

The theme song was that already hackneyed phrase " The Mother-Child Relationship " and its vital importance to the baby from the time of his conception. I would prefer today not to enter upon discussions of the validity of the recent observations on maternal deprivation. The facts are there for us to examine and amplify in the light of our own experience. From my own impressions I would like to put forward the following suggestions :—

1. That we should trace all observations to their original source and assess the evidence on which they are made. Some statements which have been made in a categorical manner would appear to be based on impressions rather than on facts, while on the other hand, statements which have been neither made nor implied have been attributed to certain authorities. Films again, are greatly enhanced in value if they can be accompanied by a commentary at least written, if not delivered, by the author and by the personal presence of someone who is thoroughly familiar with the subject and sufficiently aware of the intentions of the producer and the conditions under which the film was produced.

2. I myself think that there is now sufficient evidence of the serious effects of prolonged maternal separation on some children between the ages of 4-6 months and 3 years to make us extremely reluctant to approve of any schemes for child care which do not do everything possible to avoid such separation and to minimise its effects when it is unavoidable. It is probable that some children are more easily and more irretrievably damaged than others, but until we have discovered some means of differentiation, these children from the less susceptible I think we must regard all children as potentially vulnerable.

3. To those who have been rather depressed by Dr. Bowlby's pessimistic views about the hopelessness of attempting to treat the affectionless psychopathic child, I would like to point out that some experienced psychiatrists do not entirely agree with him. This was not actually brought out at the Chichester seminar but is well illustrated in a paragraph from a lecture on individual therapy given by Dr. Emmanuel Miller to a Scandinavian seminar on child psychiatry and child guidance work held in Norway in April, 1952. The paragraph is headed " Treatment of cases of early separation " :—

> " It is important to decide whether difficulties which have arisen from early separation were likely to respond to treatment. Some people maintain that irretrievable damage has been done and that those loveless children cannot be restored to a state of emotional relationships with other persons." I do not take that view in all cases. It is true that those who pass from that state to a psychopathic state are the most difficult to deal with.

The mother-child relationship was explored mainly by Dr. René Spitz, formerly of Vienna and now in the U.S.A., and Dr. Bowlby, two of our distinguished visiting lecturers, but our horizon was widened and the subject broadened by many others, in particular by Dr. Anna Freud and by the anthropologists represented by the colourful personality of Dr. Margaret Mead. It was broadened to include the importance of the early relations of the child to his father, brothers, sisters, grandparents and to the whole family and cultural background.

Anna Freud delighted us as usual with her complete sincerity, scientific observations, kindly humanity and clarity

of expression. She showed the value of the sibling relationship and how in a group of children deprived of their parents the children became extremely attached to one another and tended to protect the interests of the group. Jealousy is mainly elicited by the relationship with the parents and in their absence is scarcely manifest, but on the other hand, development is retarded. The Toddler Age Group is one where might is right and single age groups of children develop a primitive morality.

Miss Freud spoke of her experience in what she termed the " great involuntary experiment induced by the circumstances of war." The lessons to be learnt from this must be applied not in planning for the next war, but in our day to day schemes for child care. Brothers and sisters must not be separated and the child's social life should not be confined to his own age group ; when the mother went there was no real substitute relationship possible for the baby and when relationships were formed they were those of a much younger child.

The direct effect or separating babies of under one year from their parents was a great increase in somatic illness, whereas older children showed disturbances of emotional development and regressive phenomena. In reply to a question Miss Freud said that although she fully realised that there was often no practical alternative, children under 1½ years did not adapt well to the two routines implied by day nursery care. For older children and for short periods and in a good physical environment, nursery care might have its place. To a number of participants Miss Freud's lectures and the discussions which she led, were the high light of the seminar.

Dr. René Spitz flew from Switzerland to spend 24 hours at the seminar. He gave a most convincing account of the observations which had led to his conclusions that the child's earliest perception is that part of the mother's face which is seen from the feeding position, *i.e.*, forehead, two eyes and nose, which he describes as the " gestalt " or the whole. It is this perception which evokes baby's first smile, not the mother's smile or voice, not the smell of the milk, and if the baby is shown the profile and cannot see the second eye, he does not smile. Movement is also necessary to evoke a response. A baby recognises the human voice two months before it recognises a feeding bottle. Masks worn by the attendant have a marked disadvantage from this point of view, and later interfere with the baby's differentiation between friends and strangers and are definitely harmful to his development.

Dr. Margaret Mead was anxious to get us away from the exclusive consideration of mother and child. In many cultures father and indeed the whole family come prominently into the picture. Films taken in Bali and New Guinea showed how a baby from the earliest days was handled by the many members of his large family, and how the baby's early contact with his sisters and his cousins and his aunts affected his social development.

The French case material also brought out the tremendous importance of the grandparents, particularly in a rural society and how this was lost and needed to be replaced with something else, when the young family was uprooted and transferred to an urban setting. A similar point was made by the Americans who had wide experience of emigrant families. Here the parent consciously wishes to avoid handing on his own cultural background and yet is unfamiliar with the pattern of his adopted country—the father wishing his son to grow up different from himself cannot act as the necessary model for the child, and the mother, having lost confidence in the traditional methods of child rearing learnt from her own mother, is not yet sufficiently familiar with and cannot altogether understand the methods used in the new country.

The nursery school can and should play a vital part in giving these immigrant children a background of culture and folk lore which they can make their own, and the social worker, in advising such families should be acutely aware of their special difficulties.

Similar problems arise in dealing with the family transported from a rural to an urban environment. In France, in fact, the children are often sent back into the country to be cared for by the grandparents.

Dr. Mead's films, which were fascinating, brought out many interesting facets of patterns of child care. I don't know if you know the story of the two babies who, seated in adjacent prams were having a friendly gossip. " My mother's no good," said one, " I'm bottle fed." " My dear chap," replied the other, " you don't know how lucky you are, all my food tastes of tobacco." This story of course, contains a double-edged criticism of the modern mother, but I was very surprised and interested to see that in the film made in New Guinea the mother who was breast-feeding her baby was not only smoking a large cigar but was also playing with the toddlers at her knee, chatting away amiably to a neighbour and could yet find time to grin at the camera. Not for her the intense all-excluding concentration which Dr. Spitz showed us in his film of mothers feeding their babies. And yet, if I understood him aright, he regards this concentration as the normal and its absence tending to indicate the rejection of the child. There is here much food for thought.

Dr. Mead's babies in Bali and New Guinea have in many ways a much less exclusive relationship with their mother. From his birth, the baby is breast-fed not by his mother but by the wet-nurse, who is sent for when labour commences, gives the mother what attention is necessary and then takes over the baby. His mother takes on her maternal function when he is a few days old and already as it were " established." Here also is something to make us wonder ; later the baby is given feeds by many of his female relatives and neighbours, apparently indiscriminately, and indeed his own mother appears to deliberately tease and taunt him by withdrawing her breast and giving it to some other child. Soon his care may be handed over to the " child nurse ", who seems to be a child herself but displays much skill and intuition in his handling.

Dr. Mead suggested that this sort of early conditioning of the child might be suitable for life in a culture where the superficial apparent serenity of every day life was periodically interrupted by orgies of dance and trance. She showed us an amazing film of such dance and trance in Bali, which included the acting out of scenes representing, among other things, the birth of a baby. I hope that those of you who have not already done so will now be stimulated to read Dr. Mead's books.

Incidentally, only a little time was devoted to discussing breast-feeding.

Professor McCalman of Leeds, on opening such a discussion with my own group on the last morning, referred to Dr. Margaret Robinson's published work which had been undertaken in Liverpool and Aberdeen. I was struck by the fact that in this group the psychiatrists emphasised the relation between successful breast-feeding and physical factors such as diet, rest, general health of the mother while the paediatricians and child welfare workers laid greater stress on emotional factors. On talking this over with the paediatricians we came to the conclusion that the psychiatrists concerned had less first hand contact with lactating mothers and that it was the way in which the

mother herself spoke about the difficulties that made us inclined to think the emotional factor of importance. That is not to say that we did not appreciate the very great effect of diet, the environment, and possibly of heredity.

Weaning was mentioned as the natural maternal deprivation which every child has to face, and we agreed that the way in which this unavoidable frustration was introduced and graduated might mean much to the child's development and his reaction to other frustrating situations. Weaning is a two-way process, however, and as much trouble was caused by the mother who could not wean herself from her baby, as by the baby who was overreluctant to be weaned from his mother.

We also discussed the mother-child relationship in relation to hospital and domiciliary confinement, toilet training and enuresis, feeding difficulties and allergic conditions such as asthma, in which the child develops symptoms in situations of stress. My own group spent some time trying to define what was meant by immaturity in parents and its effects on the child.

The relation of the father came up at many points in the discussion and much interest was shown in the varying part which the father played in the home, particularly in caring for the baby, in controlling the family purse and in exercising authority. Psychiatrists stressed the importance of providing suitable father figures for the people in times of war or national catastrophe. I think myself that the concentration of our attention on the unmarried mother and our complete neglect of the unmarried father cannot be a good thing for the mental health of the community.

The husband's role during his wife's pregnancy and confinement was a subject which led to some difference of opinion. I was surprised, though I must confess not displeased, that I succeeded in shocking at least one psychiatrist. This lady seemed to be profoundly disturbed by my statement that it appeared that in this country there was a recent tendency for the husband to be present during his wife's confinement. In fact, the midwives tell me that administering the gas and air is an excellent sedative for the parturient father.

The same lady thought that this was something which no truly feminine woman could tolerate. Dr. Mead, however, rushed to my support, and stated that in primitive cultures the husband had important duties to perform and was not excluded. Whilst agreeing that the mother's wishes must of course be respected and the extent of the father's participation varied according to the circumstances, I do think that the rigid exclusion of the father may be a mistake. As Dr. Mead so aptly put it, it is time we realised that the child belongs to the mother and the father, and not to the mother and the medical services.

Here I cannot resist telling you a true story told me by a nursery school teacher. A group of nursery school children were playing at " Families," as they so often do. A small boy, who had wandered away from the group returned and went towards the door of the house. A small girl barred his way—" can't come in " she said. " But I want to come in " he replied, " this is my house." " You can't come in " said the girl, " wife's having a baby ". " Caw " said the small boy, " think I'll join the Army."

The psychiatrist previously mentioned also deplored the encouragement of a return to domiciliary confinement, and stated that she thought we had got away from such primitive procedures. On the other hand, it seemed to me that she wished us to return to a more primitive spontaneity in the mother-child relationship.

In his report of the seminar, Dr. Soddy writes as follows about Dr. Spitz's lecture and film. " The lively discussion which followed was concerned mainly with the damage incurred when the primary relationship of the baby with its mother is interrupted and the participants showed rather less shock and were less critical than might have been expected." Do I discern a hint of regret in this comment ?

On the whole, however, I got the impression that psychiatrists are now making rapid strides towards maturity. They are beginning to put into practice in their own behaviour those precepts of human relations which they have preached for some time. They have gained insight into their own limitations and some are ready to admit that, having led us to believe that they knew all the answers, they are now overwhelmed with problems for which they (as well as everyone else) have as yet no solution.

Dr. Kent Zimmerman, Chief of the Mental Health Section of the Public Health Department, California, in his lecture on " The Mental Hygiene Implications of Social Change," wisely summed up the situation as follows :—

The Mental Health Movement brings pressures upon people. So it becomes an obligation to help people to handle the pressures. There is one basic approach which can be used and focussed upon. The core and thread running through is the focus upon relationships. If we focus upon the need to develop sound relationships we have some guide. Not all people have a goal which they are seeking, but all have problems to be solved and this offers a high opportunity.

Our discussions covered many subjects which had a bearing on the mental health of the young child, and perhaps I can best give you an idea of the range of these subjects by reading to you the reports of two of the groups as they were presented at the final session of the seminar. You will, of course, realise that the writers of these reports were not English.* I can only permit myself a few comments on some of these subjects.

In the organisation of sex education, we in this country appear to be a long way behind the U.S.A. and the Scandinavian countries. Much emphasis was put on the inadequacy of the purely biological approach to sex education. The professional training of the people responsible for sex education is of supreme importance. In U.S.A. the responsibility of the parents is stressed.

The method and content of health education was suggested as a subject for a future seminar. Other suggestions were :—

1. The mental health of the toddler age group.
2. The training in mental health of professional workers.
3. The training of parents in parentcraft. This was considered to be inadequate in every country.

Birth control was not discussed except in a passing reference which deplored the W.H.O.'s decision not to discuss this subject.

The law relating to abortion seemed to vary considerably, and the Scandinavian countries would seem to take a more realistic attitude.

The attitude towards adoption also showed wide variation, and it was stated that in France, for instance, it is not possible for anyone under 40 to adopt a child.

In the countries where a medical report was requested before marriage the certificate did not include any reference to mental health.

The types and the value of mental tests for young infants and the precise function of the different members of a Child Guidance Team were discussed on several occasions.

Professor Meredith lectured on the time, space, language

* See Appendix.

and intellect of the young child, and Dr. Koupernik, of the International Children's Centre, Paris, gave us much up to date information on neuro-muscular development of infants. The latter illustrated his lecture with a very good film on locomotor development prepared by Professor Illingworth of Sheffield. This film is now available for hire, and is useful for showing to nursery nurses and student health visitiors.

Mrs. Helvi Boothe, Psychiatric Social Worker, Kansas, spoke on protection of family relationships under strain, and Mrs. Margaret Adams of New York, the only Professor of Public Health Nursing in the world, dealt with the selection and training of professional workers in the field under discussion. These two sessions were naturally followed by a discussion on the value of case work and the best training for the family visitor.

Professor Moncrieff paid a visit to the seminar, and opened one of the liveliest discussions on " Community action to improve the conditions of life of the young child." He reminded his audience that although it is the duty of the community to provide a safe environment, in a democratic country there is often opposition from the minority to commonsense measures, *e.g.* the fortification of bread by the addition of calcium had been attacked in a campaign for unadulterated food. Similar problems arose in relation to prophylactics against infectious diseases.

Professor Moncrieff outlined the steps which were being taken in children's hospitals in this country to moderate the effect of separating children from their parents. He emphasised the need for a greater concentration of effort to combat cruelty and neglect, to prevent the separation of children from their parents, and to keep sick children out of hospital whenever possible.

I am afraid that I have not given you a very coherent account of this seminar on mental health and infant development. My final impression is that it was a deeply moving and enriching experience, and that to quote a description of another seminar on mental helath—we gained " a little insight into things we know but did not know we knew." " We learned a little bit about ourselves and a little bit about the other fellow,"—about human relations in fact.

To those of us who are not psychiatrists the subject is somewhat intangible and we find difficulty in coming to grips with it. I was, however, much comforted by the remarks of a psychiatrist of one of the Latin American countries. On the morning after my lecture to the seminar he rushed up to me in the coffee break. He said, " Dr. Florentin, I want to tell you I like your lecture—very muddy lecture." As I looked somewhat startled he went on to explain. " You see, when I listen to lectures, I make into 2 kinds—the sandy lecture and the muddy lecture. The sandy lecture you listen, very nice, but after, when you take it in the hand everything run out. The muddy lecture—it stick and stick and though you wash and wash it still stick—yours very muddy lecture." Well, I am conscious today that I have not been nearly so muddy as I would have liked to be, but if I can make anything stick, I should like it to be this :—

" Public Health is People " (as Ethel Ginsberg called her account of the seminar on Mental Health in San Francisco), and I consider that mental health is a challenge to the people in the Public Health Service.

Speaking at the seminar I said that, having met our colleagues from all over the world, we of the Public Health Service felt confident about the way in which that challenge will be met. I still think that is true, but looking a little nearer home, looking at ourselves, can we be equally confident that the maternity and child welfare services in this country are going to respond adequately to that challenge ? I think that we are particularly suited to play a major part in the movement for mental health. We have unrivalled experience of the normal mother and child, we have opportunities of influencing the training of personnel, many of us have opportunities for shaping schemes for the care of mothers and children, and no one will deny that in our Maternity and Child Welfare Departments we have ample opportunity for setting a good example. in human relations. If we keep a watch upon ourselves we can also provide the breadth of outlook and balanced judgment which are so necessary.

Are we satisfied that we are preparing ourselves adequately and are going to take our full share in this important movement ? And it is a movement whose importance can scarcely be over-emphasised. Speaking at a meeting on Marriage Guidance, Dr. Torrie, the then Director of the National Association for Mental Health, made the following statement : " War begins in the minds of men, and it is in the minds of men that the defences of peace must be built. We must re-arm for emotional maturity.

Are we, I repeat, satisfied that we are ready to take up this challenge ? In the words of the well-known poster " It all depends on you."

APPENDIX

Report on Group " A "

Dr. Roudinesco, as visiting member of the Faculty, opened today's discussion by talking about the function of the " assistante sociale " in the French community. It was shown that whereas the approach of the American Social Worker to problems is educating by discussion, the approach of the French Social Worker is educating by instruction, implying an attitude of dependance of the French family on the social worker.

Whether the training be in mental hygiene or in social work, emphasis should be made upon the changing patterns of our civilisation. Mention was made of the full awareness of the U.S.A. of this point, in contrast to the rather partial and slow awareness of European countries, with its implication of partial and temporary solution of problems. Full awareness of this change was emphasised as an essential feature of any training programme. Human beings must learn to " Nest in the Gale."

The condition of the nursing staff in English hospitals was then discussed, including the relation between their different members. Special reference was made to the lack of adequate psychological background in the training of nurses, and the very important and urgent need to fill in gaps in this respect.

1. Maternal instinct—what we witness is rather a variable maternal behaviour—cultural and educational influences (such as magazines, radio, grandparents, etc.) on that pattern. Listening to radio—instead of listening to grandma.

2. Position of the father—variable role in relation to child-possible danger to relation between father and mother.

3. Reciprocity of the child-mother relation—danger of possessiveness—weaning is a two-way process.

4. Fatigue—education of the mother in the necessary reorganisation of the household to accommodate her energy resources to the needs of the infant—psychogenic fatigue arising from disturbance and mal-adjustment.

5. Anxiety, particularly in the more sensitive and intellectual types—the reduction of anxiety by appropriate guidance.

6. The changing role of the general practitioner—insistence upon his enduring importance—reorientation of the general practitioner to modern medical and psychiatric knowledge.

7. Team work—the necessity of a polyvalent approach to the needs of mother and child—the need for unity in this multi-disciplinary approach through collaborating team work.

8. The adjustment of all the organised provisions to the particular needs of the area and culture.

9. The educational problems associated with all socio-medical advances, including reciprocal disciplinary appreciation among specialists—need for attention to educational methods and techniques.

10. The value of case studies and the seven-fold relationship of the child, the two parents and the four grandparents.

11. Frustration tolerance and the problem of the relative influence of constitutional and environmental factors—great need for research.

12. Sex education—two problems: changing the public attitude and training personnel—need for wider interpretation of sex education.

13. Cinema, television, etc., and mental health—direct psychological and physiological effects of excessive attendance, and indirect influence on social standards.

14. Relationship between culture pattern and social customs—need to start from and utilise existing practices.

15. Training for public health and social work—need for high standard of training and for knowledge and understanding of family life and home problems—need for polyvalent training and integration of services.

16. Avoidance of conflict between preventive and curative services—the relation between the two services would vary from one country to another.

17. Legislation and preparation for marriage—need for attending to questions of mental health in relation to preparation for marriage and parenthood, and its bearing upon legislation.

18. Need for early treatment of maladjustment in infancy—supreme importance of the mother's personality and her relation to the child—importance of family situation.

19. Need for humanisation of health services—dangers of mechanisation—attention to psychological and physical needs in hospital organisation and architecture—associated problems of orientation and training—a general plea for more flexibility.

Report on Group "C"

Lectures and discussions related to the outlining of the best conditions under which child development should take place have enabled us to draw some general conclusions, which may prove useful to most of the countries represented at the Seminar.

It is quite obvious that patterns of life of the very civilised countries can not apply to all countries but data coming out from American experience for instance are very helpful for the organisation which may take place in less developed countries.

Avoid mistakes made by other countries, e.g., building babies' nurseries in maternity units and attempts to discourage visitors to patients in hospital.

(*a*) Some countries have to develop in the field of Mental Hygiene an understructure compatible with their actual needs and financial and human potentialities.

(*b*) Training of all personnel involved: nurses, social workers and so on has been carefully considered by the group and due attention has been paid to the importance of general cultural background and of the attitude of this personnel in his relationship from a psychological standpoint with families, patients and first of all children. Importance of psychological factors in every kind of medico-social work is to be understood by everybody in this field.

(*c*) Stages of development of the child age 0 to 2, importance of mother-child relationship and of relations of all the members of the family, adverse effects of an early separation must guide the activity of social and medico-social services and lead the social worker towards an improvement of these ties.

Education of the parents must be one of the main goals, through group work to take place in parents' associations or parents' schools. A popular drive can be expected only if the relationship in such groups is satisfactory.

Protection of the child may lead in some cases to separation from its own family and this has been the basis for creation of institutions and day-nurseries. It is highly advisable to orient administrations towards other solutions more compatible with physical and mental health of the child. Experimental evidence which has been so clearly demonstrated in this Seminar can lead to the improvement of life conditions in already existing institutions, for instance through re-organisation into small, family-like groups.

Psychological training to take place in the curriculum of paediatricians and medical students has been emphasised as important for the good functioning of departments of Child Welfare.

Creation of research-teams concerned in many countries with the study of problems of hospitalisation and life institutions has been considered as very necessary not only for scientific purposes but in the same time as means of convincing doctors, nurses, social workers and even public officers who are not yet aware of the actual importance of these problems.

Conclusion. The group as a whole has admitted that representatives of different countries can not bring on the spot solutions to the difficulties they encounter in their own countries in their various fields of activity but the general direction towards which development of Mental Hygiene in different cultures should be oriented has been sufficiently outlined.

CORRESPONDENCE

CHANGE OF NAME OF THE SOCIETY

To the Editor of PUBLIC HEALTH

SIR,—I see that an Extraordinary Meeting of the Society is to be held in September at which a resolution will be put forward to change the name of the Society to "The Society of Preventive Medicine." This is presumably the result of the postal vote which, it is understood, showed a preponderance of votes in favour of the change.

Although this important matter has been referred to from time to time in this and other journals, I have not seen any serious attempt to assess what the change will really mean. I have a certain interest in the subject since some 10 years ago I proposed to the Yorkshire Branch of the Society, my seconder being Dr. E. D. Irvine, now Medical Officer of Health of Exeter, that steps be taken to set up a Royal College of Public Health and Preventive Medicine with all the privileges and dignities of the existing Royal Colleges. This proposal, supported by people like Prof. Johnstone Jervis and Dr. J. J. Buchan, and approved unanimously by the Yorkshire Branch, was submitted to the Council of the Society, which, however, took no action. I mention this to emphasise two points: firstly, that there was never any thought in our minds that the Society of Medical Officers of Health should be in any way affected, whereas the present suggestion may mean the dissolution of the Society as it now exists; and secondly, that this question should not be considered in isolation, but only against the background of existing societies and organisations. This I will try to demonstrate.

If the proposal is agreed, eligibility for full voting membership (as opposed to associate membership) would presumably be open not only to those concerned in the practice or teaching of preventive medicine but also to people like paediatricians, obstetricians, psychiatrists and bacteriologists engaged in preventive medicine or public health. There are, however, numbers of non-medical but highly qualified bacteriologists performing first-class work in public health bacteriology. There are also a number of eminent lay statisticians doing work of the highest importance in preventive medicine. Would these be eligible for full membership of the Society? If it is agreed that lay bacteriologists and statisticians are eligible, then other professionally qualified lay people engaged in preventive medicine should also be eligible. It needs no emphasis that the bounds of preventive medicine and public health are practically indefinable, and so veterinarians, public health engineers or sanitary engineers would seemingly be eligible for admission, for it would be invidious and difficult to draw a line. On the other hand, if it is not proposed to extend the privileges of full membership to non-medical people, however highly qualified professionally or academically they may be, then the title "Society of Preventive Medicine" would be a misnomer.* (See Editor's note at end.)

The following possibilities arise:—

1. The new Society will admit to full membership all those of academic or professional standing, whether medically qualified or not, provided they are engaged in some branch of public health and preventive medicine. The result of this would be to set up a body corresponding very closely to the existing Royal Sanitary Institute, and would cause a most undesirable duplication and confusion.

2. The new Society will admit to full membership only medically qualified people provided they are engaged in public health or preventive medicine. In this case it would hardly justify its name as the Society of Preventive Medicine, but in any case it would closely correspond to the Preventive Medicine Section of the Royal Society of Medicine, which again would result in duplication and confusion.

3. The new Society will change its name only and will remain virtually the same as the existing Society. In this event the old and dignified name which clearly denotes the purpose and function of the Society will have been exchanged without any obvious benefit for a somewhat vague and indeterminate title containing no reference to health, and tending to emphasise the negativeness of medicine as against the positiveness of health.

There are, however, other and even more important points to be considered. The possibilities (1) and (2) mentioned above would almost have the effect of forming a new Society and would give rise to most undesirable duplication. There are many who say that the variety of Societies, Institutes and Associations concerned with public health and preventive medicine is a source of weakness rather than strength. For instance, there is the present Society of Medical Officers of Health, the Royal Sanitary Institute, the Royal Institute of

Public Health and Hygiene and the Preventive Medical Section of the Royal Society of Medicine. There is also the National Association for the Prevention of Tuberculosis and the National Society for the Prevention of Venereal Disease. On a somewhat different scale and category there is the London School of Hygiene and the Lister Institute of Preventive Medicine. A perusal of the list of medical societies published in the Medical Directory will indicate the variety of societies already in existence with some aspects of preventive medicine having a place in their aims and objects. It seems to me that the aim should be to bring about an amalgamation of existing organisations, rather than to set up yet another body. It is still my personal view that a College of Public Health and Preventive Medicine, comprising all sections of the public health and preventive medical services, would do more than anything else to further the cause of public health and enhance the status of its practitioners in all sections and of all categories. Unfortunately, however, the practical issues are so complex that the possibility of such a College being set up is absolutely nil at the present time.

I do, however, seriously put forward the suggestion that the time has now come to try to effect some form of combination or amalgamation of some of the well-known organisations concerned with health, hygiene and preventive medicine. It is clear that the difficulties are many—they may even be insuperable—but the possibility should at least be explored before anything is done which might have the effect merely of adding to their number.

Probably the most cogent argument for a change of name is the fact that many members of the present Society, perhaps the majority, are not actually Medical Officers of Health, but are Deputy or Assistant Medical Officers of Health. One would have thought, however, that their interests could quite well have been safeguarded in the counsels of the Society to a greater extent than they are now by forming them into groups within the Society with full representation at all levels. Thus a Deputy and Senior Medical Officers Group and an Assistant Medical Officers of Health Group would correspond in every way with the County Borough Group, the County Group and the County District Group, thereby giving each individual deputy or assistant as much personal representation as any Medical Officer of Health now has.

It is well to ask what representation deputies and assistants can look for in the new Society when Medical Officers of Health themselves would form only a comparatively small proportion of the membership and would have to share their representation with all other sections and interests.

Yet another very important factor is the fact that the new Society would cease to speak mainly for Medical Officers of Health or for those engaged in the local government public health service. In a field of activity having such immensely wide ramifications as that of preventive medicine and public health, there must be, and there undoubtedly are, many sectional interests; to quote one example, the opinion of Medical Officers of Health in general does not always correspond with that of the generality of paediatricians. When a Government Department or other official body consults the Society of Medical Officers of Health, it is seeking the advice and opinion of men who are engaged in the public health services of the local authorities. The advice of other sections or groups concerned with public health and preventive medicine, such as bacteriologists or paediatricians, is available through the societies formed exclusively from such people, for example, the British Paediatric Society. The change of constitution necessarily following the new name will mean, therefore, if carried through to its fullest extent, that the opinion of the Society will not necessarily express the considered view of the public health services only, but that many other interests will also be represented. Such an opinion is almost bound to be a compromise opinion and as such might well militate against the interests of the public health service and the public health generally.

It seems to me, therefore, that there will always need to be, and indeed there always must be, a Society of Medical Officers of Health, the chief purpose of which is to express the viewpoint and safeguard the professional interests of medical men engaged in the local government public health services; and this, where necessary, even against those of other professional men, both medical and lay, also concerned with public health and preventive medicine. Other groups of medical men, from anaesthetists to medical superintendents, have their own societies or associations; there is a Society of Directors of Education and a Society of Town Clerks—undoubtedly there must also be a Society of Medical Officers of Health.

Finally, what will be the effect of the change of name on the prestige and status of Medical Officers of Health? Could a more inopportune moment have been chosen? There are unmistakeable signs that the loss of prestige which we suffered in 1948 is being recovered, and yet at this very moment the Society decides virtually to dissolve itself and to abolish any reference to health or Medical Officers of Health from its title. From the self-interest point of view it is surely a foolhardy step. It is often asked to what do Town Clerks owe their prestige and importance, both in central and local government counsels. The answer, surely, is that it is to a large extent due to the fact that they have a strong and well-known Society of Town Clerks able to speak uncompromisingly for them. Town clerks are certainly not noticeably lacking in shrewdness and business acumen. Can we imagine their Society suddenly transforming itself into some such body as "The Society for Municipal Law and Administration?" Everybody at the moment knows what the Society of Medical Officers of Health is and stands for, in much the same way as they know what the Society of Town Clerks stands for, although perhaps not to the same degree. Nobody will know about or pay any attention to the pronouncements of "The Society of Preventive Medicine."

I have touched upon a few, but only a few, of the many difficult and imponderable questions which ought to be considered in relation to a change of name of our Society. It is clear that the change of name is only one of the factors about which we ought seriously to be thinking, as, for instance, the possible amalgamation of existing organisations, but with the continuance of a strong Society of Medical Officers of Health. I would have thought that before any irrevocable decision is taken the proper course would be for an *ad hoc* Committee to be set up, representing all interests within the Society, with the duty of considering carefully all the many factors which are involved. The report of this Committee should be made available to all members of the Society for their guidance. It may, of course, be too late now for anything to be done, but I venture to put the suggestion forward even at this late stage.—Yours faithfully,

J. Tudor Lewis,

Medical Officer of Health, Metropolitan Boroughs of Wandsworth and Battersea; Divisional Medical Officer, London County Council Health Division 9.

Municipal Buildings,
Wandsworth, S.W.18.

July 6th, 1953.

• As there still appears to be some misunderstanding on the question of present eligibility for membership of the Society we quote Article 4 of the current Articles of Association of the Society, which has been in force for several years. Fellows have the right of voting, Associates do not.—*Editor*, PUBLIC HEALTH.

"4. *Membership.*—The Association shall comprise Honorary Fellows, Fellows and Associates.

(*a*) Honorary Fellows shall be persons who are eminently distinguished in the advancement of public health.

(*b*) Fellows shall be:—

(1) Medical officers of health, acting or retired, whether in the British Isles and dependencies or elsewhere.

(2) Medical or dental officers, acting or retired, of Government Departments, whether in the British Isles or dependencies or elsewhere.

(3) Medical or dental officers, acting or retired, of the Navy, Army and Air Force (at home or abroad) who hold or who have held appointments in connection with hygiene.

(4) Medical practitioners engaged or having been engaged in the teaching of subjects of public health, child health or social medicine in universities or medical schools.

(5) Medical or dental officers holding, or having held, administrative, specialist, or clinical appointments in connection with any branch of public health work, including hospitals, maternity and child welfare, the school health service, port health, tuberculosis, venereal diseases, industrial hygiene, fevers, mental diseases, ophthalmology, bacteriology, dentistry, etc.

(6) Registered medical practitioners holding a Diploma or Certificate in Sanitary Science, Public Health or State Medicine under Section 21 of the Medical Act, 1886.

(*c*) Associates shall be persons of professional standing interested in the advancement of public health."

OBITUARY

ARTHUR BERRY MCMASTER, M.D., R.U.I., D.P.H., V.U. (MANCH.)

Dr. A. B. McMaster, whose death occurred recently in his 79th year, was Medical Officer of Health and Port Medical Officer for Dover from 1920 to 1939, and after retirement from that post, continued work during the second world war as M.O.H. for Sandwich and the adjoining districts of Kent. A Northern Irishman, he turned to public health, as M.O.H., Crewe, when his health broke down under the strain of general practice. He was an active and zealous public health officer and was for a time the representative of the County District M.O.H. Group on the Council of the Society. Older members wil recall his handsome, rather shaggy, appearance and pleasant courtesy of manner.

ERNEST GOODWIN RAWLINSON, M.D., C.M. (TORONTO), L.R.C.P. & S. (EDIN.), L.F.P.S. (GLASGOW), D.P.H. (OXON.)

The death on July 4th, of Dr. Goodwin Rawlinson, a few days after the announcement of his retirement as Dean of the Royal Institute of Public Health and Hygiene, has taken away a man who instructed several generations of D.P.H. students at Queen Square. Rawlinson, who returned to the land of his birth after initial qualification in Canada, came to public health teaching under the late Sir William Smith of the R.I.P.H., via posts in bacteriology and pathology. He continued as Director of the Department of Bacteriology at Queen Square after the merger of the Royal Institute with the Institute of Hygiene in 1937, in 1942 became Dean and in 1949 Director of Laboratories. He was elected a Fellow of the Society of M.O.H. in 1922 as was his son, Dr. M. P. G. Rawlinson (now in Canada), in 1949.

We are indebted to Dr. J. A. Struthers for the following presonal tribute:—

"A well-known writer once said that the only epitaph which he coveted for himself was one which he saw in a country churchyard—'He was a helpful man.' These words certainly applied to Dr. Goodwin Rawlinson. His help was readily given to all those—patients, students, colleagues and staff—with whom he came into contact; and he would take great pains to see that the help given was what was really wanted. By no means the least valuable element in the help was kindness and readiness with which it was always given. To the hundreds of students whom he taught in the course of years there must remain an ineffacable memory of his kindness, courtesy and sympathetic understanding, which were unfailing. The least censorious of men in his opinion of others, he never spared himself in his efforts to give of his best for those for, and with whom, he worked. He had hoped to devote himself in his retirement to painting and etching, in both of which he had done good work; but this was not to be. He will be sorely missed; but he made brighter the lives of many."

JOHN STOKOE, M.D., B.S. (DURH.), B.HY., D.P.H.

We record with regret the sudden death on July 11th, of Dr. John Stokoe, Medical Officer of Health for Scarborough M.B., and R.D. and "Scalby" U.D., and Divisional M.O. for that and of the North Riding. Dr. Stokoe who was in his early fifties, graduated from Durham University in 1924, proceeded M.D. in 1938 and took the D.P.H. in 1936. His first public health post was as A.M.O.H., Derby C.B., whence he went as M.O.H. and S.M.O., Blyth. He served as Lieut.-Colonel R.A.M.C. in the second world war. His premature death sadly anticipates by a few months the visit of the R.S.I. Congress to his borough in April, 1954. He became a Fellow of the Society of M.O.H. in 1937.

ALBERT FORSTER, M.B., B.S. (DURH.), D.P.H.

Dr. Albert Forster, Medical Officer of Health for Chester-le-Street R.D., for several years, and latterly also for Chester-le-Street, U.D., died suddenly on July 22nd. He qualified at Durham University in 1942 and took the D.P.H. in 1950 after several years hospital experience. He joined the Society in the same year. His early death adds to the number of members of the public health service who have been lost in their prime in recent years.

Back Numbers of Public Health.—The central office stocks of the journal issued since October last are very low. The Administrative Officer would be glad to receive back any unwanted copies on which postage would be refunded.

SOCIETY OF MEDICAL OFFICERS OF HEALTH

HOME COUNTIES' BRANCH

President: Dr. J. Maddison (M.O.H., Twickenham M.B., and Area M.O., Middlesex).

Hon. Secretary: Dr. F. G. Brown (M.O.H., Wanstead and Woodford M.B., and Area M.O., Essex).

A cruise up the River Thames on Tuesday afternoon, June 16th, 1953, made an enjoyable change for the June meeting of the Branch. Over 60 members and guests, including the Mayor and Mayoress of Twickenham, boarded the *Cardinal Wolsey* launch at Richmond. The launch proceeded up river through Teddington Lock, past Kingston and Hampton Court, turning back just before Molesey Weir. Tea was served on board. Although the weather was showery, everyone enjoyed the many interesting things to be seen on this pleasant stretch of the river.

METROPOLITAN BRANCH

President: Dr. F. R. Waldron (Divisional M.O., L.C.C.).

Hon. Secretary: Dr. F. M. Day (M.O.H., Hammersmith Met.B.).

A meeting of the Branch was held in B.M.A. House, Tavistock Square, W.C.1, on Friday, February 13th, 1953, under the chairmanship of the President. Forty-seven members and visitors were present.

The minutes of a meeting of the Branch held on Friday, December 12th, 1952, were read, confirmed and signed by the Chairman.

A number of apologies from members unable to be present were submitted.

The President announced that the "Metropolitan Branch Essay Prize" for 1952 had been awarded to Dr. W. G. Harding for his paper on "Public Health and the Midwife," and presented him with a cheque for the amount of the prize. Dr. Harding suitably responded.

It was unanimously agreed to nominate Dr. C. F. White, O.B.E., Medical Officer of Health to the Corporation of London, for the Presidency of the Society for the year 1953-54. Dr. White thanked the members for the honour accorded to him.

Two interesting and instructive addresses dealing with "The Diagnosis and Treatment of Spastic Paralysis in Children" and illustrated by photographic slides were delivered by Dr. C. D. S. Agassiz, Physician Superintendent, Queen Mary's Hospital for Children, Carshalton, and Mrs. Eirene Collis, C.P.T., M.C.S.P., etc., who is in charge of the Cerebral Palsy Unit at the hospital. The papers and discussion are printed on other pages of this issue.

NORTH-WESTERN BRANCH

President: Dr. K. K. Wood (M.O.H., Bury C.B.).

Hon. Secretary: Dr. J. S. G. Burnett (M.O.H., Preston C.B.).

The annual meeting of the Branch was held at Newton in Bowland on Friday, June 12th, 1953, at 3 p.m., when 21 members and guests attended.

Apologies for absence from 27 members were received. The meeting heard with interest of the activities of absent friends at the Fruit Growers' Conference in Hampshire, at the M. & C.W. Conference in London, and with salmon on the banks of the Spey and with alarm at the epidemic sickness that had apparently deacended that morning on the medical members of a large north-western health department.

The minutes of the annual meeting held at Langho on Friday, June 13th, 1952, were read and approved as a true record.

The annual report of the Hon. Treasurer, in his unavoidable absence, was presented by the Hon. Secretary, whose persuasive elaboration of the highly satisfactory position revealed in the Treasurer's accurately prepared and carefully audited report left the meeting in considerable doubt and the report was approved with reluctance.

The election of officers and committee for the ensuing year took place, when the following were elected:—

President.—Dr. S. C. Gawne.

Vice-President.—Dr. K. K. Wood.

Hon. Secretary.—Dr. J. S. G. Burnett.

Hon. Treasurer.—Dr. J. Yule.

Representatives to the Council.—Dr. J. S. G. Burnett and Dr. J. Yule.

Committee.—Drs. H. G. M. Bennett, C. Metcalfe-Brown, F. W. C. Brown, J. G. Hailwood, J. Innes, E. M. Jenkins, J. T. C. Keddie, M. Sproul, C. H. T. Wade, E. H. Walker.

A short discussion took place on restrictive practice in relation to a recent Whitley C. agreement and it was agreed that a further report be submitted on the events leading up to the acceptance of this principle.

The company was then entertained to tea by the President and his lady.

WEST OF ENGLAND BRANCH

President: Dr. B. A. Astley-Weston (M.O.H., Bath C.B.).
Hon. Secretary: Dr. R. H. G. H. Denham (M.O.H., Bathavon, Frome, etc.).

Joint Meeting with Welsh Branch

A joint meeting of the West of England and Welsh Branches of the Society was held at Bath on Saturday, May 9th, 1953. This was attended by 34 members and 23 guests.

The party met at the Pump Room for luncheon and tea. After luncheon Dr. Kersley gave an address at the Royal Mineral Water Hospital on "Recent Advances in the Treatment of Rheumatic Diseases." This was supplemented by a film showing the modern methods of treatment by hydrotherapy, etc.

Thanks to the speaker for providing an interesting and instructive afternoon were ably expressed by Dr. Greenwood Wilson.

A lively and most enjoyable dinner-party was given in the evening by the members of the Welsh Branch which the President and Secretary of the West of England Branch attended as guests.

The week-end was agreeably rounded off by a sightseeing tour of the city on the following Sunday morning.

NORTH-WESTERN M. & C.W. and S.H.S. SUB-GROUPS

President: Dr. Margaret Sproul (Sen. M.O., M.C.W., Salford C.B.).
Hon. Secretary: Dr. E. M. Jenkins (Sen. S.M.O., Manchester C.B.).

A meeting of the Groups was held in the Public Health Committee Room, Third Floor, Town Hall Extension, Manchester, on Friday, March 27th, at 5 p.m.

Nineteen members were present.

The speaker, Mr. G. L. C. Elliston, M.A., Executive Secretary of the Society, was introduced by the President. He gave a most interesting and illuminating talk on the general aim and activities of the Society.

Mr. Elliston explained that he had dropped the executive title and had become part-time in a consultative capacity, as he would be almost fully occupied as Editor of PUBLIC HEALTH and Deputy Editor of *The Medical Officer*.

In tracing the history of the Society Mr. Elliston referred to the Askwith Memorandum of 1929 and pointed out that the office of the Society was not much concerned now with "trade unionism." The aims and objects remained those of a learned society. He spoke very highly of certain Medical Officers of Health, such as C. Metcalfe Brown, Buchan, Cowan, Fenton and Picken, who had worked hard in the interests of the Public Health Service. The Society now had 2,100 members. It had its jubilee in 1906 and the history of the second 50 years was now being written. It had considerable influence on national bodies and its educative function was exemplified by the refresher courses. Clinical and other Groups and Branch meetings allowed exchange of ideas.

A lively discussion followed in which Dr. Crawford reiterated the statement that general practitioners have little or no interest in the work of preventive medicine. Doctors' surgeries were in effect largely first aid posts giving pills for diarrhoea and for children with fits, whereas certain members of the Public Health Service were really specialists in "well baby clinics." He did not think that the public would relinquish the benefits they had come to expect from the Public Health Service. He referred to the proposed change of title of the Society and asked what benefits might be expected to offset the loss of prestige and tradition which will result from the change. At the same time the Society attracted a wide variety of members, including some specialists and general practitioners. Dr. Webster asked Mr. Elliston who was putting the case of the Public Health Medical Officer before the public eye? The present division of the health services was a political one brought about by wrong advice and the Society was tending to attract now only newly qualified, young and ignorant people.

Dr. Crawford then asked the members to give a vote of thanks to Mr. Elliston for coming to Manchester and for his interesting and stimulating address. This was applauded with much vigour.

BOOK REVIEWS

Pulmonary Tuberculosis: A Handbook for Students and Practitioners. By R. Y. KEERS, M.D., F.R.F.P.S., F.R.C.P.E., and B. G. RIGDEN, M.R.C.S., L.R.C.P.—3rd edition. (Pp. 324). Price 24s. net). Edinburgh: E. & S. Livingstone. 1953.

In a preface to the third edition of this excellent handbook the authors point out that the six years since the appearance of the last edition have been among the most eventful in the history of tuberculosis, to be compared with the closing years of the last century when the tubercle bacillus was first identified and *x*-rays discovered. Most of the book has been rewritten, therefore, and, commendably, kept to its former convenient size—an important consideration in a volume intended for students and practitioners. A feature of the book is the large number of well-produced reproductions of skiagrams of cases of respiratory tuberculosis, which show, also, the results of the various methods of treatment and the assessment of progress; many non-tuberculous conditions illustrating the differential diagnosis are also portrayed.

The chapters on epidemiology and resistance, after-care, and prevention, are up-to-date, and they summarise present knowledge and its application very well: from the point of view of the public health medical officer, however, these chapters might well have been expanded a little, particularly in respect of such matters as rehousing and the employment of the infectious ambulant patient. The remarks on B.C.G., though short, are well considered. This little book will form a useful addition to the library of the public health department.

Glen's Public Health Act, 1936. 16th edition of Glen's Public Health. Edited by the Hon. Sir PATRICK REDMOND BARRY and H. A. P. FISHER, M.A. (Pp. 745. Price 75s.) London: Eyre & Spottiswoode (Publishers), Ltd., 1953.

The first edition of this standard work, which is now nearing its centenary, was prefaced by William Cunningham Glen from Gwydyr House, Whitehall (the home of the Local Government Board), in October, 1858, and dealt mainly with the Public Health and Local Government Acts of 1848. In fact, it had a forerunner in a book of 1848, also by Glen, dealing with the Nuisances Removal Act. This went into several editions with amendments made by subsequent legislation until the first edition of Glen proper appeared. William Glen edited the forerunner and the first six editions of the present work single-handed and was joined in the 8th, 9th and 10th editions by his son, Alexander Glen, K.C. The latter, with A. F. Jenkin (and latterly his son, Randolph Glen), edited the 11th, 12th and 13th. The 14th edition, the last edited by a Glen (Randolph), ran to nearly 3,000 pages, showing the bulk to which public health legislation had accumulated before the great consolidation of 1936. Miss Bright Ashford, the learned lady who was editor-in-chief of the 15th edition in 1936, was able to deal with the subject in 685 pages. The new editors have been able to omit many of the longer notes comparing the 1936 Act with pre-consolidation statutes and so to keep within a handy compass the additions and amendments to the law in the intervening 16 years.

There is an interesting discussion by the present editors, in an introduction to Part V of the 1936 Act, of the effects of the National Health Service Act, 1946, on the health duties of "minor" authorities. The notes on Part V sections are as useful as ever.

University of London Model Welfare Centre

A building licence has now been issued for the model child welfare centre and school clinic which is the first part of the development plan of the Institute of Child Health of the University of London. This new building is made possible by the magnificent gift received some years ago from the South African "Aid to Britain Fund." Part of the special portion of the fund raised on the Province of Natal was used for this purpose and the new project is therefore financed by what has been termed the "Natal Gift," a sum originally amounting to over £106,000. A site has been purchased by the University at the corner of Guilford Place and Guilford Street (at the north end of Lambs Conduit Street, W.C.1.). Eventually it is hoped to provide buildings for the Institute of Child Health along the adjoining portion of Guilford Street where it will form a link between the buildings of The Hospital for Sick Children, Great Ormond Street and the welfare centre.

The new biuldings will provide on the ground floor facilities for normal maternity and child welfare centre work and on the first floor for school clinic work. The London County Council, as the Local Health and Education Authority, will by agreement with the Institute of Child Health, be responsible for a substantial portion of the costs of maintenance and of the salaries of staff.

The centre will be used for demonstrative purposes for the post-graduate students of the Institute who come from all parts of the world, in particular from the Commonwealth. If is significant of the interest which the people of South Africa take in child health that the largest national group of students from overseas at the Institute comes from that country. The new centre will also serve a valuable purpose for the study of the healthy child and thereby provide an important contribution to the development of preventive work for this section of the community. Plans for the building are at an advanced stage and preparation of the site is to start forthwith. Messrs. Easton and Robertson are the architects, the firm employed by the Hospital for Sick Children for the rebuilding of the Hospital where a new out-patient department is nearing completion of its first stage.

OFFICIAL NOTICES

County Borough of Preston

APPOINTMENT OF MALE ASSINTANT MEDICAL OFFICER OF HEALTH

Applications are invited from registered medical practitioners for the above appointment.

The duties will include maternity and child health, school health and port health duties, together with such other duties as may be allotted by the Medical Officer of Health.

The possession of the D.P.H. or D.C.H. will be an advantage. Salary in accordance with the Industrial Court Awards.

The person appointed will be required to pass a medical examination and to contribute to the superannuation fund.

Application forms may be obtained from the Medical Officer of Health, Municipal Buildings, Preston, and should be returned to the undersigned not later than August 15th, 1953.

W. E. E. LOCKLEY,
Town Clerk.

Municipal Buildings,
Preston.

County Borough of Blackpool

PUBLIC HEALTH DEPARTMENT

Applications are invited for the appointment of DISTRICT NURSES. Applicants must possess S.R.N. certificate and preference will be given to those who have passed an approved course in district nursing.

Applications are invited for the appointment of a HEALTH VISITOR. Applicants must possess S.R.N. AND S.C.M. certificate and must have the Health Visitor's certificate of the Royal Sanitary Institute.

Salary and conditions of service in accordance with the awards of the Nurses and Midwives Whitley Council.

Forms of application and full particulars may be obtained from the Medical Officer of Health, Whitegate Drive, Blackpool.

TREVOR T. JONES,
Town Clerk.

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